General Assembly **Substitute Bill No. 6444**

January Session, 2003

AN ACT CONCERNING CONTRACTS BETWEEN MANAGED CARE ORGANIZATIONS AND PROVIDERS AND THE RECODING OF HEALTH INSURANCE CLAIMS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective January 1, 2003)* (a) As used in this section, (1) "managed care organization" means a managed care organization, as defined in section 38a-478 of the general statutes, (2) "provider" means a provider, as defined in section 38a-478 of the general statutes, (3) "enrollee" means an enrollee, as defined in section 38a-478 of the general statutes, (4) "commissioner" means the Insurance Commissioner", and (5) "recode" or "recoding" means the changing, by a managed care organization on a claim submitted by a provider, of a code or group of codes for health care services for the purpose of reimbursing the provider at a lower rate. "Recode" or "recoding" includes, but is not limited to, the reduction of an evaluation or management service level, the combining of codes for two or more separate and distinct services or procedures performed on a single patient during a single office visit, the change of a code to a different classification code, or the bundling of physician services codes in any manner that conflicts with the American Medical Association's Current Procedural Terminology coding policy or instructions.

(b) On and after January 1, 2004, any provider who is aggrieved by a recoding and who has exhausted any internal mechanisms provided

by a managed care organization to appeal such recoding may appeal the recoding to the Insurance Commissioner in accordance with this section.

(c) (1) To appeal a recoding, a provider shall, within thirty days from receiving a final written determination from the managed care organization, file a written request for appeal with the commissioner. The appeal shall be made on forms prescribed by the commissioner and shall include the filing fee provided for in subdivision (2) of this subsection and a general release executed by the enrollee for all medical records pertinent to the appeal.

(2) The filing fee shall be twenty-five dollars and shall be deposited into the Insurance Fund established in section 38a-52a of the general statutes.

(3) Upon receipt of the appeal together with the executed release and appropriate fee, the commissioner shall assign the appeal for review to an entity engaged by the commissioner pursuant to subsection (d) of this section.

(4) Upon receipt of the request for appeal from the commissioner, the entity conducting the appeal shall conduct a preliminary review of the appeal and accept the appeal if such entity determines: (A) The provider has or had a contract or other arrangement with the managed care organization; (B) the benefit or service that is the subject of the appeal reasonably appears to be a covered service, benefit or service under the agreement provided by contract to the enrollee; (C) the provider has exhausted any internal appeal mechanisms provided to the provider by the managed care organization; and (D) the provider has provided all information required to make a preliminary determination including the appeal form, a copy of the final recoding decision and a fully-executed release to obtain any necessary medical records from the managed care organization, enrollee and any other relevant provider.

(5) Upon completion of the preliminary review, the entity

conducting the review shall immediately notify the provider in writing as to whether the appeal has been accepted for full review and, if not so accepted, the reasons therefor.

(6) If accepted for full review, the entity shall conduct such review in accordance with the regulations which the Insurance Commissioner shall adopt, after consultation with the Commissioner of Public Health, in accordance with chapter 54 of the general statutes.

(d) To provide for such review the Insurance Commissioner, after consultation with the Commissioner of Public Health, shall engage impartial health entities to provide medical review under the provisions of this section. Such review entities shall be known as an external board of review and shall be composed of representatives from (1) medical peer review organizations, (2) independent utilization review companies, provided any such company is not related to or associated with any managed care organization, and (3) nationally recognized health experts or institutions approved by the commissioner.

(e) The commissioner shall accept the decision of the external board of review and shall notify the managed care organization or its agent and the provider of the decision. If the external board of review finds that the claim should not have been recoded, the managed care organization shall pay the provider the amount of the claim plus interest at the rate of fifteen per cent per annum except that no interest shall be due if the board finds that the recoding resulted from the provider's failure to submit necessary claim information. If the external board of review finds that the recoding was justified, the provider shall pay the managed care organization a penalty in the amount of fifteen per cent of the amount of the claim. The decision of the commissioner shall be binding and final.

(f) The requirements of subdivision (15) of section 38a-816 of the general statutes shall continue to apply and shall not be affected by the procedures set forth in this section.

This act shall take effect as follows:	
Section 1	*January 1, 2003*

INS *Joint Favorable Subst.*